

**FAMILY SUPPORT APPLICATION**

Name of Person with Disability \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Name of Parent/Guardian \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_  
 Person Submitting Request \_\_\_\_\_ Telephone \_\_\_\_\_  
 (Your relationship to person with disability)

**PLAN**

Describe the services/supports requested, the costs, and the period of time covered: \_\_\_\_\_

Describe the reason(s) supports are needed and expected benefits: \_\_\_\_\_

Have other resources been considered for these supports? Please list: \_\_\_\_\_

Amount Requested: \$ \_\_\_\_\_

☐ I agree to use Family Support and In-Home Assistance money in accordance with the Developmental Disabilities Family Support and In-Home Assistance Act. In selecting and receiving services from providers/vendors, I agree that the Department of Health and Welfare *is not* responsible or liable for any incident adversely affecting the health, safety, or welfare of \_\_\_\_\_.

(Name)

☐ I choose to directly receive the payments. I understand that I must obtain the agreed upon services or equipment and maintain documentation of expenditures. I further understand and agree that by my direct receipt of these funds, I am assuming potential tax and employer responsibilities that may include, but are not limited to, worker's compensation, employee withholding, unemployment insurance, and liability insurance.

☐ I choose to have the vendor paid directly.

Vendor's Name

Vendor ID #

Vendor Telephone #

Address

Signature of Parent/Guardian

Date

**FOR OFFICE USE ONLY:**

I have reviewed the application and attached documentation and approve \$ \_\_\_\_\_ for \_\_\_\_\_.

**METHOD OF PAYMENT:**

☐ Paid to family in advance

☐ Paid to family *after* service provided

☐ Paid to provider/vendor

☐ APPROVED

☐ NOT APPROVED

Authorizing Signature

Date